MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

## Medical Services • General Medicine

**June 2007 • Bulletin 396**

### Contents



### 2007 CPT-4/HCPCS Updates: Implementation August 1, 2007

The 2007 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after August 1, 2007. Specific policy changes are detailed below. Unless otherwise stated, the policy of deleted code(s) applies to the replacement code(s). Providers are reminded that Medi-Cal enforces CPT-4 instructions.

**SURGERY**

**Deleted and Replacement Codes**

| Deleted Code(s) | Replacement Code(s) |
|---|---|
| 15000 – 15001 | 15002 – 15005 |
| 17304 – 17310 | 17311 – 17315 |
| 19140 – 19240 | 19300 – 19307 |
| 25611 | 25606 |
| 25620 | 25607 – 25609 |
| 26504 | 26390 |
| 27315 | 27325 |
| 27320 | 27326 |
| 28030 | 28055 |
| 33253 | 33254 – 33256 |
| 35381 | 35302 – 35306 |
| 35541 | 35537 – 35538 |
| 35546 | 35539 – 35540 |
| 35641 | 35637 – 35638 |
| 48005 | 48105 |
| 48180 | 48548 |
| 49085 | 49402 |
| 54820 | 54865 |
| 55859 | 55875 |
| 56720 | 56442 |
| 67350 | 67346 |

**Billing Restrictions**

CPT-4 codes 17311 – 17315 (Mohs micrographic surgery) require a *Treatment Authorization Request* (TAR) for primary surgeons. These codes are not reimbursable for assistant surgeons.

Code 19300 (mastectomy for gynecomastia) requires a TAR and is restricted to males only.

Codes 19301 – 19307 (mastectomy) require a TAR.

Code 22849 (reinsertion of spinal fixation device) will not be reimbursed with codes 22850, 22852 or 22855 unless there is documentation that the procedure was performed at a different spinal level, same date of service, any provider.

*Please see* **HCPCS/CPT-4**, *page 2*

**HCPCS/CPT-4** *(continued)*

Code 22857 will not be reimbursed with codes 22558, 22845, 22851 or 49010 unless there is documentation that the procedure was performed at a different spinal level, same date of service, any provider.

Code 22862 will not be reimbursed with codes 22558, 22845, 22851, 22865 or 49010 unless there is documentation that the procedure was performed at a different spinal level, same date of service, any provider.

Code 28055 (neurectomy) requires a TAR when billed by podiatrists.

Codes 32998 (ablation therapy) and 49324 – 49326 (laparoscopy) are non-benefits for assistant surgeons.

Codes 33675 – 33677 (closure of multiple ventricular septal defects), 33724 (repair of isolated partial anomalous pulmonary venous return) and 33726 (repair of pulmonary venous stenosis) are reimbursable for a second assistant surgeon.

Code 37210 (uterine fibroid embolization) is reimbursable for females only.

Codes 44157 and 44158 (colectomy and ileoanal anastmosis) are once-in-a-lifetime procedures.

Codes 54865 (exploration of epididymis), 55875 (transperineal placement of needles or catheters into prostate) and 55876 (placement of interstitial device(s) for radiation therapy guidance) are restricted to males only.

Codes 56442 (hymenotomy) and 57558 (dilation and curettage of cervical stump) are restricted to females only and are non-benefits for assistant surgeons.

Codes 57296, 58541 – 58544, 58548 and 58957 – 58958 (female genital surgical procedures) are restricted to females only.

Codes 58541 – 58544 and 58548 (laparoscopy) require a hysterectomy consent form; all codes are once-in-a-lifetime procedures.

**Add-On Codes**

The following CPT-4 codes are add-on codes and must be billed on the same claim with the corresponding code for the primary procedure:

| Add-On Code | Primary Procedure Code(s) |
|---|---|
| 15003 | 15002 |
| 15005 | 15004 |
| 17312 | 17311 |
| 17314 | 17313 |
| 17315 | 17311 – 17314 |
| 35306 | 35305 |
| 49326 | 49324 – 49325 |
| 49435 | 49324, 49421 |

All of the add-on codes listed above are exempt from the multiple surgery cutback when billed with modifier 51.

*Please see* **HCPCS/CPT-4**, *page 3*

**HCPCS/CPT-4** *(continued)*

**RADIOLOGY**

HCPCS code A9549 (technetium Tc-99-m arcitumomab, diagnostic, per study dose) was terminated and is no longer a Medi-Cal benefit.

**Deleted and Replacement Codes**

| Deleted Code(s) | Replacement Code(s) |
|---|---|
| 76012, 76013 | 72291, 72292 |
| 76778 | 76775, 76776 |
| 76986 | 76988 |
| 75998 | 77001 |
| 76003 | 77002 |
| 76005 | 77003 |
| 76355 | 77011 |
| 76360 | 77012 |
| 76362 | 77013 |
| 76370 | 77014 |
| 76393 | 77021 |
| 76394 | 77022 |
| 76095 | 77031 |
| 76096 | 77032 |
| 76082, 76083 | 77051, 77052 |
| 76086 | 77053 |
| 76088 | 77054 |
| 76090, 76091 | 77055, 77056 |
| 76092 | 77057 |
| 76093, 76094 | 77058, 77059 |
| 76006 | 77071 |
| 76020 | 77072 |
| 76040 | 77073 |
| 76061, 76062 | 77074, 77075 |
| 76065, 76066 | 77076, 77077 |
| 76075, 76076 | 77080, 77081 |

**Billing Restrictions**

HCPCS code A9527 (iodine I-125) is a 100 percent professional service and must be billed with modifier ZS.

The following CPT-4 codes must be billed with the appropriate split-bill modifiers (26, 99, TC or ZS): 76776, 77001 – 77003, 77011, 77012, 77014, 77021, 77022, 77031, 77032, 77051 – 77059, 77072 – 77077, 77080 and 77081.

Codes 72291, 72292 76998, 77013, 77071, 77371 – 77373 and 77435 are 100 percent professional services and must be billed with modifier 26.

The professional component of codes 77001 – 77081 cannot be billed on the same date of service as Evaluation and Management (E&M) codes 99201 – 99499 (except 99211 or 99358).

Codes 77031, 77032, 77055 – 77057 (mammography) are reimbursable under the Breast Cancer Early Detection Program.

Screening mammograms (codes 77052 and 77057) are reimbursable to females 35 – 39 years of age as a baseline; only one screening is reimbursable for women within this age range. Women 40 years of age and older are restricted to one screening per year. There is no diagnostic restriction.

Diagnostic mammograms (codes 77051, 77055 and 77056) are reimbursable to males and females, and there is no age restriction. The claims must be billed in conjunction with one of the following diagnostic codes: 174.0 – 174.9; 175.0 – 175.9; 198.81; 198.89; 233.0 – 233.09; 238.3 – 238.39; 239.3 – 239.39; V10.3 – V10.39; V16.3 – V16.39 or V76.10 – V76.19.

Codes 77058 and 77059 (magnetic resonance imaging) require a *Treatment Authorization Request* (TAR).

*Please see* **HCPCS/CPT-4**, *page 4*

**HCPCS/CPT-4** *(continued)*

**PATHOLOGY**

**Billing Restrictions**
The following CPT-4 codes must be billed with the appropriate split-bill modifiers (26, 99, TC or ZS): 82107, 83698, 83913, 86788, 86789, 87305, 87498, 87640, 87641, 87653 and 87808.

Code 88314 is not reimbursable with codes 17311 – 17315 for a routine frozen section stain. However, it is separately reimbursable for a non-routine frozen section stain when it is billed with modifier 59.

Codes 88302 – 88309 (surgical pathology) are not reimbursable with codes 17311 – 17315 (Mohs surgery) unless there is documentation that the pathology claims are for different specimens.

**MEDICINE**

**Deleted and Replacement Codes**

| Deleted Code(s) | Replacement Code(s) |
|---|---|
| 94656 – 94657 | 94002, 94003 |

**Billing Restrictions**
CPT-4 codes 94002 – 94003 (ventilator management) and 94644 – 94645 (continuous inhalation treatment) require a *Treatment Authorization Request* (TAR) or Medi reservation when performed by a Respiratory Care Practitioner.

Providers are reminded that preventative medicine CPT-4 codes 99381 and 99391 have age restrictions of younger than one year; code 99382 is restricted to recipients 1 through 4 years of age.

**OPHTHALMOLOGY**

**Deleted and Replacement Codes**

| Deleted Code | Replacement Code |
|---|---|
| C9225 | J7311 |

**Billing Restrictions**
CPT-4 code 92025 (computerized corneal topography) is reimbursable to optometrists within their scope of practice. When billing code 92025, providers must document in the *Reserved for Local Use* field (Box 19) of the claim or on an attachment that the service was provided according to one of the following criteria:

- Pre- or post-operatively for corneal transplant (codes 65710, 65730, 65750 and 65755) or corneal correction surgery (codes 65772 and 65775)
- Pre- or post-operatively prior to cataract surgery due to irregular corneal curvature or irregular astigmatism
- In the treatment of irregular astigmatism as a result of corneal disease or trauma
- To assist in the fitting of contact lenses for patients with corneal disease or trauma (ICD-9-CM diagnosis codes 371 – 371.9)
- To assist in defining further treatment

Code 92025 is not covered under the following conditions:

- When performed pre- or post-operatively for non-Medi-Cal covered refractive surgery procedures such as 65760 (kerato mileusis), 65765 (keratophakia), 65767 (epikeratoplasty) and 65771 (radial keratotomy)
- When performed for routine screening purposes in the absence of associated signs, symptoms, illness or injury

*Please see* **HCPCS/CPT-4**, *page 5*

**HCPCS/CPT-4** *(continued)*

**DRUGS, INJECTIONS AND BLOOD FACTORS**

**Deleted and Replacement Codes**

| Deleted Code | Replacement Code |
|---|---|
| J7188 | J7187 |
| X7484 | Q4084 |

**Billing Restrictions**

Injection code C9233 (ranibizumab [Lucentis™]) is reimbursable with prior authorization. Providers must document on the *Treatment Authorization Request* (TAR) that the patient has exudative senile macular degeneration (ICD-9-CM code 362.52). Reimbursement is limited to 12 injections per eye, per year. Providers should bill with the appropriate site modifiers (LT, RT or 50 if bilateral). C9233 must be billed on the same claim as CPT-4 code 67028 (intravitreal injection of a pharmacologic agent).

Injection codes J0348 (andulafungin, 1mg) may be billed up to 200 mg and must be billed with ICD-9-CM diagnosis codes 112 – 112.9.

Injection code J0894 (decitabine, 1 mg) is reimbursable for patients with myelodysplastic syndrome. Claims must be billed with ICD-9-CM diagnosis codes 238.72 – 238.75. Maximum dosage for three consecutive days is 122 mg per day unless there is documentation that the Body Surface Area (BSA) is greater than 2.7 $m^2$. Treatment may be repeated in six weeks.

Injection code J1740 (ibandronate sodium, 1 mg [Boniva™]) is reimbursable for the treatment of women with post-menopausal osteoporosis. Claims must be billed with ICD-9-CM diagnosis code 733.01. Providers must submit the following documentation, either in the *Reserved for Local Use* field (Box 19) or on an attachment:

- A diagnostic T score of -2.5 or more in women who have documented difficulty with the oral bisphosphonates dosing requirement, which includes an inability to sit upright for 30 to 60 minutes and/or difficulty in swallowing a pill; or
- A diagnostic T score of -2.5 or more in women with documented esophagitis, gastritis, gastric or esophageal ulcers that prohibit the use of oral bisphosphonates

Dosing frequency is 3 mg every three months administered intravenously over 15-30 seconds by a health care provider. Boniva is contraindicated in patients with hypocalcemia or those who have a known hypersensitivity to ibandronate sodium.

Code J2248 (micafungin sodium, 1 mg) may be billed up to 150 mg and must be billed with ICD-9-CM diagnosis codes 112-112.9.

Code J3243 (tigecycline, 1 mg) may be billed up to 100 mg.

HCPCS codes J7611 and J7613 (albuterol inhalation solution, 1 mg) will be added as Medi-Cal benefits. Claims billed in excess of 30 mg will be cut back unless the provider submits documentation, either in the *Reserved for Local Use* field (Box 19) or on an attachment, that the patient required more than the allowed amount due to continued airflow obstruction.

Injection code J9261 (nelarabine, 50 mg) is reimbursable to patients with lymphosarcoma or acute lymphoid leukemia. Claims must be billed with ICD-9-CM diagnosis codes 200.10 – 200.18 or 204.00 – 204.01. Maximum daily dosage on days one, three and five is 4,050 mg unless documentation BSA is greater than 2.7 $m^2$. Treatment may be repeated in 21 days.

*Please see* **HCPCS/CPT-4**, *page 6*

**HCPCS/CPT-4** *(continued)*

Injection code J9035 (bevacizumab 10 mg [Activa®]) will be activated to replace deleted code S0116 (bevacizumab, 100 mg).

- Code J9035 must be billed in conjunction with diagnosis codes 153.0 – 154.8 (malignant neoplasm of the colon, rectum, rectosigmoid junction and anus) or 162.2 – 162.9 (malignant neoplasm of bronchus and lung).
- The provider must document that treatment was either for metastatic colorectal cancer or for unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer.

Bevacizumab is packaged in 100 mg vials. If it is necessary to waste the unused portion of a vial, providers may bill for a quantity that is equal to the amount given to the patient plus the amount wasted. Providers must justify in the *Reserved for Local Use* field (Box 19) of the claim the amount of bevacizumab that was wasted.

Injection codes Q4084 (Synvisc), Q4085 (Euflexxa) and Q4086 (Orthovisc) are reimbursable, with prior authorization.

The TAR may be approved for one or both knees when there is documentation of one of the following conditions:

- Painful osteoarthritis of one or both knees
- Significant knee pain, decreased mobility, or significant effusion of one or both knees
- Knee pain that is not relieved with use of non-steroidal anti-inflammatory drugs (NSAIDs)

Quantity and frequency restrictions:

- Synvisc and Euflexxa are restricted to a total of three injections per knee (one injection, one week apart, for a total of three weeks) in a six month period
- Orthovisc is restricted to a total of four injections per knee (one injection, one week apart, for a total of four weeks) in a six month period

The manual replacement pages reflecting these policies will be released in the July *Medi-Cal Update.*

### Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) are being redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFO).

TAR services currently handled by the FMCFO will be redirected as follows:

- Intravenous home infusion equipment services, including all medical supplies related to infusion therapy, and all Durable Medical Equipment (DME) and medical supplies related to enteral feeding, have been redirected to the NPS and SPS.
- Medical supplies related to incontinence, including urinary catheters and bags, have been redirected to the SMCFO.
- Breast pumps and supplies have been redirected to the SFMCFO.
- Physician-administered drugs and/or physician-performed services/procedures, radiology services, inpatient and outpatient surgeries and procedures that require a TAR and elective acute hospital admissions have been redirected to the SMCFO.

Providers located in Oregon border cities were required to submit their TARs, for core services only, to SMCFO effective May 1, 2004.

The California Department of Health Services (CDHS) does not anticipate any delays in adjudication of these TAR types.

*Manual replacement pages will be released in a future Medi-Cal Update.*

### Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

**Processing Change Schedule**
Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

| | |
|---|---|
| **May 2007** | **August 2007** |
| Sacramento Medi-Cal Field Office | Fresno Medi-Cal Field Office |
| **June 2007** | San Bernardino Medi-Cal Field Office |
| Northern Pharmacy Section (Stockton) | San Diego Medi-Cal Field Office |
| Southern Pharmacy Section (L.A.) | San Francisco Medi-Cal Field Office |
| **July 2007** | **September 2007** |
| L.A. Medi-Cal Field Office | TAR Administrative Remedy Section |
| In-Home Operations South | In-Home Operations North |

**Incomplete TARs**
CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.

*Please see* **Processing Changes**, *page 8*

**Processing Changes** *(continued)*

- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

**Adjudication Response**
CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

**Attachments**
On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

*Please see* **Processing Changes**, *page 9*

**Processing Changes** *(continued)*

**SSN on TARs**

In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

**National Provider Identifier (NPI) Number**

Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

State of California - Health and Human Services Agency
Department of Health Services

CONFIDENTIAL

Medi-Cal Operations Division

ARNOLD SCHWARZENEGGER, Governor

# ADJUDICATION RESPONSE

Provider Number: HSCXXXXXX
XXX CONTRACT HOSP #2
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 06/27/2006
Regarding: Jane Doe
TAR Control Number: 9876543210

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

| Svc # | Service Code | Modifier(s) | Service Description | From Date of Service | Thru Date of Service | Units | Quantity | Status | P.I. |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 123ABC | 1 | Service Description 1 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 1 Approve | 1 |
| 2 | ABC123 | 2 | Service Description 2 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 2 Modify | 0 |
| | **Reason(s):** | GEN: Modified, refer to comments | | | | | | | |
| | **Comment(s):** | Comments from Field Office Consultant 2 | | | | | | | |
| 3 | ABC123 | 3 | Service Description 3 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 3 Deny | 3 |
| | **Reason(s):** | GEN: Denied, refer to comments | | | | | | | |
| | **Comment(s):** | Comments from Field Office Consultant 3 | | | | | | | |
| 4 | ABC123 | 4 | Service Description 4 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 4 Defer | 5 |
| | **Reason(s):** | GEN: Deferred, refer to comments | | | | | | | |
| | **Comment(s):** | Comments from Field Office Consultant 4 | | | | | | | |

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

## New Digital Mammography and Computer Aided Detection Benefits

Effective retroactively for dates of service on or after December 1, 2006, the following two codes are new Family PACT (Planning, Access, Care and Treatment) program mammography benefits.

| Code | Description |
|---|---|
| G0202 | Screening mammography, producing direct digital image, bilateral, all views |
| 76083 | Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure) |

**Restrictions**
CPT-4 code 76083 is only reimbursed with HCPCS code G0202 or CPT-4 code 76092 when findings warrant further physician (radiology) review for interpretation. Code 76083 must be billed with one of the appropriate primary procedure CPT-4 codes.

Family PACT recipients are limited to either one analog (film) or one digital screening mammogram per year. The following restrictions apply for both codes:

- Recipients must be females 40 – 55 years of age.
- All primary ICD-9-CM diagnosis codes apply except S601 – S602 and S801 – S802.
- One screening is provided per year, any provider.

Providers may resubmit previously denied claims until October 1, 2007 for dates of service on or after December 1, 2006.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers.

## 2007 CPT-4/HCPCS Updates: Implementation August 1, 2007

The 2007 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for the Family PACT (Family Planning, Access, Care and Treatment) Program for dates of service on or after August 1, 2007. Specific policy changes are detailed below.

**CPT-4 Codes with Description Changes**
The following codes contain new or revised text: 76856, 76880, 90761, 99251 – 99255

**Deleted and Replacement Codes**

| Deleted Code | Replacement Code |
|---|---|
| 49085 | 49402 |
| 54820 | 54865 |
| 76083 | 77052 |
| 76090 | 77055 |
| 76092 | 77057 |

**Billing Restrictions**
CPT-4 code 49402 (removal of peritoneal foreign body from peritoneal cavity) is reimbursable for females only. It requires a *Treatment Authorization Request* (TAR) and a primary diagnosis code (PDC) of S4032 or S4033.

Code 54865 (exploration of epididymis, with or without biopsy) is reimbursable for males only. It requires a TAR and a PDC of S8031 or S8033.

*Please see* **Family PACT**, *page 11*

**Family PACT** *(continued)*

Code 77052 (computer aided detection [computer algorithm analysis of digital image data for lesion detection] with further physician review for interpretation, with or without digitalization of film radiographic images; screening mammography [list separately in addition to code for primary procedure]) is reimbursable for females 40 – 55 years of age. It is limited to one per recipient, per year, any provider. It requires any PDC except S60 and S80. Code 77052 must be billed with one of the primary procedure CPT-4 codes. It may be used with CPT-4 code 77057 or HCPCS code G0202 only when further physician (radiology) review is warranted for interpretation of findings.

Code 77055 (mammography; unilateral) requires a PDC of S3031 and is reimbursable for females only.

Code 77057 (screening mammography, bilateral [2-view film study of each breast]) is reimbursable for females 40 – 55 years of age. It is limited to one per recipient, per year, any provider. It requires any PDC except S60 or S80. Recipients are limited to either one screening film mammogram (code 77057) or one screening digital mammogram (code G0202) per year, any provider.

## New Infant Formula for WIC

Effective August 1, 2007, the California Women, Infants and Children (WIC) Supplemental Nutrition Program will change its infant formula rebate contract from Ross Laboratories to Mead Johnson Nutritionals. The WIC Program will provide the following Mead Johnson standard infant formulas:

- Enfamil LIPIL with Iron (milk-based)
- Enfamil LactoFree LIPIL (milk-based)
- Enfamil Gentlease LIPIL (milk-based)
- Enfamil AR LIPIL (milk-based)
- Enfamil ProSobee LIPIL (soy-based)

Mead Johnson's Enfamil Gentlease LIPIL will replace Nestle Good Start Supreme as the partially hydrolyzed protein formula and will not require a prescription.

Infant formula change can create concern for some parents of young infants. However, the infant formula rebate generates enough income for the WIC Program to provide nutritious food and nutrition services to 350,000 additional California participants each month, 23 percent of which are infants. Therefore, providers are requested to:

- Reassure parents that standard infant formulas are very similar and that changing formula should not cause health problems
- Encourage parents that any discomforts related to a formula change are temporary and should last no more than 3 to 4 days

**Formulas for Medical Conditions**

The WIC Program will continue to provide formulas for medical conditions using established procedures. For WIC Program participants who are Medi-Cal recipients, benefits include products designed to treat diagnosed conditions when medical justification can be demonstrated. WIC may also provide these formulas on a temporary basis to patients while they complete the Medi-Cal application and enrollment process.

For additional information about formulas for medical conditions available through WIC, or to find the phone number of any local WIC agency, providers can visit the WIC Web site at **www.wicworks.ca.gov**.

### Enzyme Replacement Drugs Reimbursement Update

Effective for dates of service on or after July 1, 2007, the following codes are now Medi-Cal benefits.

| HCPCS Code | Description |
|---|---|
| C9232 | Idursulfase, 1 mg, is for the treatment of Hunter syndrome (Mucopolysaccharidosis Type II [MPS II]). |
| C9234 | Alglucosidase alfa, 10mg, is for the treatment of Pompe Disease. |
| J1458 | Galsulfase, 1 mg, is for the treatment of Maroteaux-Lamy Syndrome (Mucopolysaccharidosis Type VI [MPS VI]). |

A *Treatment Authorization Request* (TAR) is required for the reimbursement of enzyme replacement drugs and must be submitted to the Los Angeles Medi-Cal Medical (not Pharmacy) Field Office (LAMFO). Initial drug therapy will be approved on a 3- or 6-month trial basis. Renewal of the TAR will require that follow-up documentation be submitted to the field office. For children under 21 years of age, a Service Authorization Request (SAR) should be made through California Children's Services (CCS).

See the "TAR Requirements" subsection under the specific drug name in the *Injections* section of the appropriate Part 2 provider manual for specific information on TAR submissions.

**HCPCS Code Updates and Reminder**
Age restrictions are removed from both laronidase (code J1931) and agalsidase beta (code J0180). Also, the correct diagnosis for laronidase is "Mucopolysaccharidosis Type I or Hurler, Hurler-Scheie or Scheie's syndrome."

*This information is reflected on manual replacement pages inject 58 thru 60 (Part 2) and inject list 2, 8 and 9 (Part 2).*

### Pegaspargase: New Benefit to Treat Acute Lymphoid Leukemia

Effective for dates of service on or after July 1, 2007, pegaspargase (Oncaspar), single dose vial (HCPCS code J9266) is reimbursable for acute lymphoid leukemia. Code J9266 must be billed in conjunction with an ICD-9-CM diagnosis code in the range 204.00 – 204.01. The maximum reimbursable dosage per day is two single dose vials.

*This information is reflected on manual replacement pages chemo 20 (Part 2) and inject list 14 (Part 2).*

### CDP: EWC Mammography Policy Clarification

Cancer Detection Programs: Every Woman Counts (CDP: EWC) providers are reminded that the mammography policy stated in *Medi-Cal Updates* also applies to CDP: EWC and that reimbursement of mammograms is restricted to recipients 40 years of age and older.

More than one screening mammogram (CPT-4 code 76092) performed by the same provider on the same woman within 365 days will not be reimbursed. In addition, all diagnostic mammograms (CPT-4 codes 76090 and 76091) require an ICD-9-CM code for reimbursement. For complete policy information, see the April 2007 *Medi-Cal Update*.

Because CDP: EWC claims are processed by Medi-Cal, the program must follow Medi-Cal policy for CPT-4 code reimbursement. Therefore, all mammography reimbursement policy stated in *Medi-Cal Updates* also applies to CDP: EWC with the exception of digital mammography which is not a covered benefit of CDP: EWC.

### Xeroradiography, Mammography Codes Billable on Same Date of Service

Effective for dates of service on or after July 1, 2007, providers may bill CPT-4 code 76150 (xeroradiography) with either code 76090 or 76091 (mammography) for the same date of service, for the same recipient. This allows providers to perform both xeroradiography and mammography when necessary. Code 76150 is used for non-mammographic studies only.

*Information previously denying such claims is removed from manual replacement page radi dia 24 (Part 2).*

### New Spinal Neurostimulator Services Added

Effective for dates of service on or after July 1, 2007, two new spinal implantable neurostimulator generator codes are benefits. In addition, a third code for an external battery recharging system is also a benefit.

The following codes were made benefits:

| HCPCS Code | Description |
|---|---|
| C1767 | Generator, neurostimulator (implantable), nonrechargeable |
| C1820 | Generator, neurostimulator (implantable), with rechargeable battery and charging system |
| L8695 | External recharging system for battery (external) for use with implantable neurostimulator |

Providers also must submit a copy of the invoice for reimbursement.

Providers must submit a *Treatment Authorization Request* (TAR) for the surgical procedure (CPT-4 codes 63650, 63655 and 63685) and provide sufficient documentation of the following:

- Pathological basis for the pain (pain has been greater than six months in duration)
- Conventional medical treatments (drugs, surgery, physical and/or psychological) having failed or were clinically judged to be unsuitable or contraindicated. Spinal cord stimulation using implantable devices is felt to be the last resort
- No existing contraindication to implantation, such as sepsis or coagulopathy
- Patient completing a three- to seven-day trial of percutaneous spinal stimulation with a temporarily implanted electrode, with at least a 50 percent or more reduction in pain
- A multidisciplinary team's (neurosurgeon, physical therapist, psychiatrist, etc.) evaluation of the patient for the appropriateness of the spinal stimulator, and the patient screening for any untreated substance abuse disorder and psychiatric problems
- The patient's demonstration that he or she is capable of operating the device
- All the facilities, equipment, professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the patient are available
- Further surgical intervention is not indicated

A few examples of when these services may be authorized include, but are not limited to, failed back syndrome, complex regional pain syndrome (for example, reflex sympathetic dystrophy), spinal cord injury, arachnoiditis, radiculopathies, end-stage peripheral vascular disease when the patient cannot undergo re-vasularization and phantom limb/stump peripheral neuropathy.

A few examples of when these services may not be authorized include, but are not limited to, pain related to a malignancy, brachial plexus injury, intractable angina, multiple sclerosis, spastic torticollis and nociceptive pain.

*This information is reflected on manual replacement pages surg nerv 2 and 3 (Part 2).*

### CPT-4 Codes 58290 and 58291 No Longer Require Assistant Surgeon TARs

Effective July 1, 2007, CPT-4 codes 58290 (vaginal hysterectomy, for uterus greater than 250 g) and 58291 (vaginal hysterectomy, for uterus greater than 250 g, with removal of tubes and/or ovaries) no longer require *Treatment Authorization Requests* (TARs) for assistant surgeons.

*This information is reflected on manual replacement page tar and non cd5 6 (Part 2).*

### Billing Ranibizumab with HCPCS Code J3590

Providers are reminded to use HCPCS code J3590 (unclassified biologics) when billing for ranibizumab, a drug used in treatment of exudative senile macular degeneration. This drug requires a *Treatment Authorization Request* (TAR), which must be sent to the appropriate Medi-Cal field office with required documentation. For instructions to bill for J3590, providers may refer to "Unlisted Injections: HCPCS Codes Billed 'By Report' " in the *Injections* section.

**Note:** The policy for code J3590 will only be effective through date of service July 31, 2007. On August 1, 2007, providers should use code C9233 (ranibizumab) when it becomes effective as part of the 2007 HCPCS code update.

HCPCS updates will be released in a future Medi-Cal provider bulletin.

### Infliximab Diagnoses Expanded

Effective for dates of service on or after July 1, 2007, infliximab (Remicade) 100 mg (HCPCS code X7480) is now reimbursable for the treatment of plaque psoriasis.

Documentation stating that plaque psoriasis covers 10 percent or more of the patient's body surface area must be on or attached to an approved *Treatment Authorization Request* (TAR).

*This information is reflected on manual replacement page inject 44 (Part 2).*

### Billing Code for Abatacept Revised

Effective for dates of service on or after July 1, 2007, abatacept (Orencia) 10 mg is billed with HCPCS code J0129 rather than code J3590 (unclassified biologics).

Abatacept is approved for the treatment of moderate to severely active rheumatoid arthritis (RA) in adult recipients, 18 years of age or older. A *Treatment Authorization Request* (TAR) is required and must document that the patient has had an inadequate response after treatment with:

- Two or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs), and
- At least one of the tumor necrosis factor (TNF) antagonists (infliximab, etanercept or adalimumab) or the interlukin-1 receptor antagonist, anakinra (inadequate response after at least one month of treatment).

In addition, the TAR must include all of the following:

- A requested dose of abatacept for 1000 mg or less (a quantity of "100" or less in the quantity field of the TAR)
- ICD-9-CM code 714.0, 714.1 or 714.2
- Documentation that the patient is 18 years of age or older

*This information is reflected on manual replacement pages inject 45 and 46 (Part 2) and inject list 2 (Part 2).*

### Nonspecific ICD-9-CM Codes Not Billable with a Lab Procedure Code

Effective for dates of service on or after July 1, 2007, the following nonspecific ICD-9-CM diagnosis codes are not billable with a laboratory procedure code: V70, V70.0, V70.5 – V70.9, V72, V72.1 and V72.9.

This does not change the policy that any laboratory procedure must be billed with a diagnosis code, nor does it change the policy requiring specific diagnosis codes for certain laboratory procedures. Providers billing a laboratory procedure code with any of the above diagnosis codes will have their claims denied for nonspecific diagnosis.

*This information is reflected on manual replacement page path bil 1 (Part 2)*

### Expanded Coverage for Gemcitabine Reimbursement

Effective for dates of service on or after July 1, 2007, reimbursement for HCPCS code X7630 (gemcitabine, 200 mg) will be expanded to include ICD-9-CM diagnosis codes 200.00 – 202.98 (malignant neoplasm of lymphatic and hematopoietic tissue).

*This information is reflected on manual replacement page chemo 11 (Part 2).*

### Updated VFC Coverage and Influenza Vaccine Codes Reimbursement

The Vaccine for Children (VFC) Program has updated its coverage of free vaccines. The following is a complete list of these CPT-4 vaccine codes: 90633, 90647 – 90649, 90655 – 90658, 90660, 90669, 90680, 90700, 90707, 90710, 90713 – 90716, 90723, 90734, 90743, 90744 and 90748. For detailed descriptions of these codes, see the *Vaccine For Children (VFC) Program* section in the Part 2 provider manual.

Providers should also be aware that influenza vaccines (CPT-4 codes 90655 – 90658) are now considered routine injections and do not require "high risk" documentation or the use of modifier SK for administration fee reimbursement.

*This information is reflected on manual replacement pages modif used 4 (Part 2) and vaccine 2 thru 4 (Part 2).*

### Transesophageal Echocardiography Reminder

Providers are reminded that effective for dates of service on or after January 1, 2007, transesophageal echocardiography CPT-4 codes 93313, 93314, 93316 and 93317 are no longer Medi-Cal benefits.

CPT-4 codes 93312, 93315 and 93318 are still Medi-Cal benefits and must be billed with the appropriate modifiers: 26, TC or ZS.

Frequency restrictions for each code remain four per year, per recipient, by any provider.

### Medi-Cal Share of Cost and Medicare Part D Reminder

Medicare-eligible recipients with a Medi-Cal Share of Cost (SOC) are not eligible for Medi-Cal benefits until their SOC is met. Under the Medicare Part D prescription drug program, Medicare beneficiaries with a Medi-Cal SOC may have higher prescription drug payment obligations than beneficiaries without an SOC. These payment obligations may include deductibles and copayments.

All medically necessary health services, whether covered by Medi-Cal or not, can be used to meet SOC for Medi-Cal purposes. All prescription drug payments required under Medicare Part D are considered medically necessary health services. For more information, refer to the Part 1 provider manual.

Prescription drug payments required under the Medicare Part D prescription drug program should be applied to the recipient's SOC upon receiving payment or accepting obligation for payment from the recipient. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

### Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs.*

**Addition, effective May 1, 2006 (incorrectly removed previously)**

| **Drug** | **Size and/or Strength** |
|---|---|
| ***** PAPAIN AND UREA | |
| Ointment | |
| * Restricted to NDC labeler codes 50484 (Smith & Nephew, Inc.) and 58980 (Stratus Pharmaceuticals) only. | |

**Change, effective August 1, 2006**

| **Drug** | **Size and/or Strength** |
|---|---|
| * ZOLPIDEM TARTRATE | |
| + Tablets | 5 mg |
| | 10 mg |
| + Tablets, extended-release | 6.25 mg |
| | 12.5 mg |
| * Restricted to use in the treatment of insomnia **and to NDC labeler code 00024 (Sanofi-Aventis) only.** | |

**Change, effective April 9, 2007**

| **Drug** | **Size and/or Strength** |
|---|---|
| TEMOZOLOMIDE | |
| Capsules | 5 mg |
| | 20 mg |
| | 100 mg |
| | **140 mg** |
| | **180 mg** |
| | 250 mg |

**Change, effective May 15, 2007**

| **Drug** | **Size and/or Strength** | |
|---|---|---|
| ***** OXICONAZOLE NITRATE | | |
| Cream | 1% | 15 Gm |
| | | 30 Gm |
| | | 60 Gm |
| ~~*** Restricted to claims submitted with dates of service through March 31, 2006.**~~ | | |
| Lotion | 1% | 30 cc |
| *** Restricted to** NDC labeler code 00462 (PHARMADERM) **only**. | | |

\+ Frequency of billing requirement

*Please see* **Contract Drugs**, *page 17*

**Contract Drugs** *(continued)*

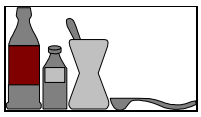
**Changes, effective June 1, 2007**

| **Drug** | **Size and/or Strength** |
|---|---|
| CALCIUM ACETATE | |
| + Tablets or capsules | 667 mg |
| ~~**(NDC Labeler Code 59730 [Nabi] only.)**~~ | |
| PREDNISOLONE SODIUM PHOSPHATE | |
| Oral solution | 20.2 mg/5cc |
| (NDC labeler code 68135 [Biomarin Pharmaceuticals, Inc.] only.) | |
| *** Orally disintegrating tablets** | **10 mg** |
| | **15 mg** |
| | **30 mg** |
| *** Restricted to NDC labeler code 68188 (Alliant Pharmaceuticals, Inc.) only for orally disintegrating tablets.** | |
| * RISPERIDONE | |
| Tablets | 0.25 mg |
| | 0.5 mg |
| | 1 mg |
| | 2 mg |
| | 3 mg |
| | 4 mg |
| Solution | 1 mg/cc |
| * Restricted to individuals **5** years of age and older. | |

**Changes, effective August 1, 2007**

| **Drug** | **Size and/or Strength** | |
|---|---|---|
| ALBUTEROL SULFATE | | |
| + Tablets or capsules | 2 mg | |
| | 4 mg | |
| + Long-acting tablets | 4 mg | |
| | 8 mg | |
| * Inhaler (without chlorofluorocarbons as the propellant) | 6.7 Gm | |
| * Restricted to dates of service from October 1, 1996 to January 31, 2007. | | |
| Solution for inhalation | 0.5 % | 20 cc |
| Solution for inhalation, premixed | 0.083 % | |
| | * 1.25 mg/3cc | |
| *** Restricted to NDC labeler code 49502 (Dey L.P.) only for 1.25 mg/3 cc.** | | |
| | 0.63 mg/3 cc | |
| Liquid | 2 mg/5 cc | |
| Capsules for inhalation with inhalation device | Package containing 96 or 100 capsules and one inhalation device | |
| Capsules only, for inhalation | | |
| ***** FLUNISOLIDE | | |
| Nasal spray | 0.025 % | 25 cc |
| *** Restricted to claims for NDC labeler code 59310 (IVAX Labs, Inc.) and with dates of service before August 1, 2007.** | | |

\+ Frequency of billing requirement



**DRUG USE REVIEW**
***Educational Information***

## Follow-Up Care for Attention Deficit Hyperactivity Disorder (ADHD) in Medi-Cal FFS Population

Attention Deficit Hyperactivity Disorder (ADHD) is considered one of the most widespread childhood behavioral complaints that physicians address.[1] The symptoms of ADHD can impact multiple areas related to children's performance in their everyday activities at school, home or in the community. There is some concern about over-diagnosis of ADHD and increase in stimulant use for treatment of ADHD. It has been shown that stimulant medication can increase the capacity for the patient to stay on task and follow rules, and can decrease emotional outbreaks. The American Academy of Child and Adolescent Psychiatry (AACAP) has recommendations for the care of children with ADHD.[2] Their recommendations include:

- Providers should institute management programs to treat ADHD as a chronic condition.
- Treatment evaluation should include the patient, family, teachers and other adults in the patient's life.
- Environmental and behavioral techniques should be included with drug therapy.
- Follow-up with the patient to target outcomes and decrease side effects.

Follow-up care for ADHD includes:

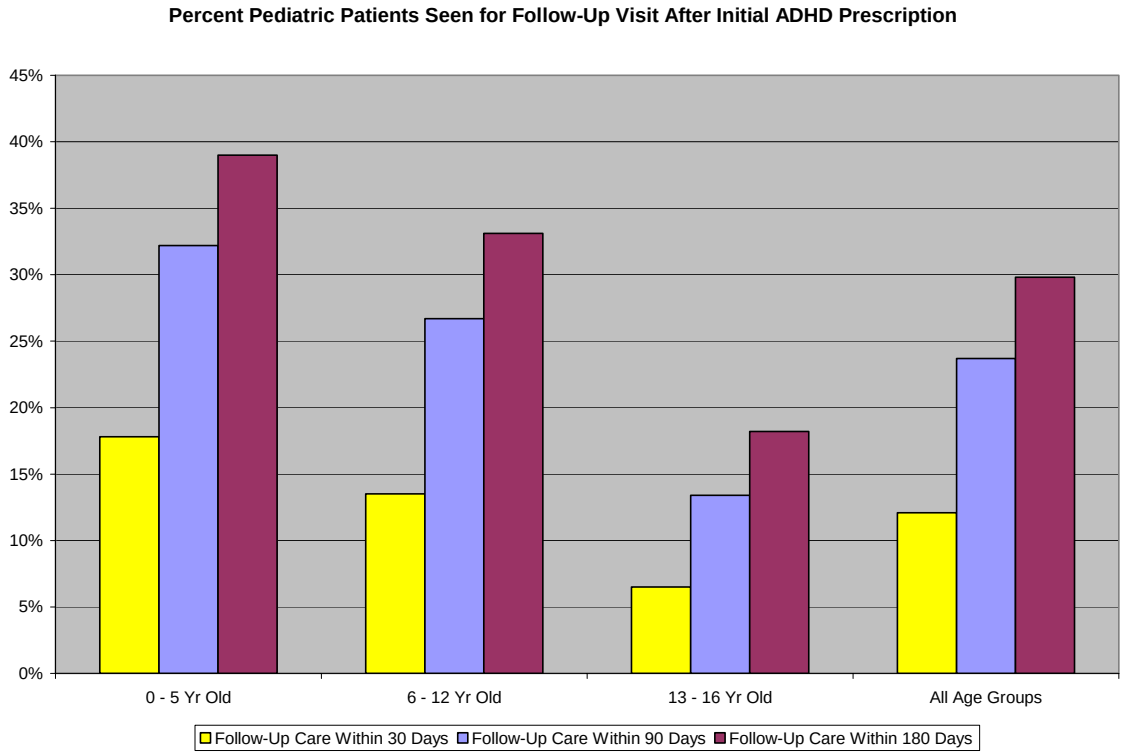
- Should be instituted the month after medications are initiated. [3]
- Follow-up office visits at periodic time intervals after the patient is stabilized on an appropriate dose. This number should be individualized to the patient's clinical needs. [4]

A retrospective study of Medi-Cal Fee-For-Service (FFS) recipients was conducted that measured the extent that recipients had medical follow-up visits after initiating ADHD medication therapy. It is recognized that physician phone follow up cannot be tracked through administrative claims and, therefore, could not be identified in this analysis. Recipients who were continuously eligible throughout the January 2006 to March 2007 period and started ADHD drug therapy between July 2006 through September 2006 were included in the study.

- 1,247 Medi-Cal recipients under age 17 had claims for ADHD drugs during the study period and met the continuous eligibility criteria.
  - Over 39 percent of the recipients between 0 – 5 years old had follow-up care within 180 days after starting drug therapy, though less than 18 percent had follow-up care within 30 days as recommended by the AACAP
  - Overall, follow-up care within 180 days after initiating ADHD drug therapy decreased in older age groups, as 33 percent of recipients between 6 – 12 and only 18 percent of recipients between 13 – 16 had follow-up doctor visits after initiating ADHD drug therapy
  - Median number of days before the first follow-up visit was 37 days for the recipients seen within 180 days of initiating ADHD drug therapy

*Please see* **Follow-Up**, *page 19*

**Follow-Up** *(continued)*




Overall, pediatric patients are getting follow-up care when diagnosed with ADHD and receiving medication to treat the condition. The percentage of patients receiving follow-up within AACAP recommendations could be improved upon. Medi-Cal recommends:

- Providers follow current AACAP recommendations for treatment and follow-up for patients with an ADHD diagnosis
- Schedule follow-up visits at periodic intervals
- Providers obtain information on the efficacy of the medication from multiple caregivers, including family, teachers and the community
- Pharmacists inquire when patients pick up medications that a follow-up visit has been scheduled and are always available to discuss the advantages and side effects of ADHD medications

**References**

1. Rushton JL, Fant KE, Clark SJ. Use of practice guidelines in the primary care of children with attention-deficit/hyperactivity disorder. *Pediatrics* 2004; 114(1):e23-e28.
2. American Academy of Child and Adolescent Psychiatry. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder. **www.aacap.org/galleries/PracticeParameters/New_ADHD_Parameter.pdf**. 2007.
3. Harpaz-Rotem I, Rosenheck RA. Prescribing practices of psychiatrists and primary care physicians caring for children with mental illness. *Child Care Health Dev* 2006; 32(2):225-237.
4. American Academy of Child and Adolescent Psychiatry. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder. **www.aacap.org/galleries/PracticeParameters/New_ADHD_Parameter.pdf**. 2007.

*Please refer to pages 36-39 and 36-40 in the Medi-Cal Drug Use Review manual.*

# Instructions for Manual Replacement Pages — Part 2

**June 2007**

## General Medicine Bulletin 396

| | |
|---|---|
| Remove and replace at the end of *Manual Ordering* section: | *Subscriber Order Form* 1/2 * |
| Remove and replace: | chemo 11/12, 19/20<br>child 1 thru 4 *<br>cont ms 3/4 *<br>forms reo ma 1/2 *<br>inject 43 thru 46, 57 thru 60<br>inject list 1/2, 7 thru 10, 13/14, 19<br>medi non hcp 1/2 *<br>modif used 3/4<br>oth hlth cpt 1/2 *<br>path bil 1/2<br>preg com exc 7/8 *<br>radi dia 23/24<br>surg nerv 1 thru 4<br>tar and non cd5 5/6<br>tar comp 1 thru 13 * |
| Remove: | tar sub clk 1 thru 3 |
| Remove and replace: | tar submis 3 * |
| Remove:<br>Insert: | tar submit 1/2<br>tar submit 1 * |
| Remove and replace: | transplant 5/6 *<br>vaccine 1 thru 4 |

### *DRUG USE REVIEW (DUR) MANUAL*

| | |
|---|---|
| Insert: | 36-39/36-40 |

* Pages updated due to ongoing provider manual revisions.